Delivering data-informed and goal-oriented transitional care for older adults in Ontario: Practical nurses' perspectives on challenges and successes using standardized comprehensive assessments

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Introduction

- **Community-based transitional care programs** that facilitate access to coordinated and continuous care following an acute care hospitalization **are growing across Canada**.[1]
- **Person-centred care planning is a program expectation,** including dialogue-based assessment, collaborative goal setting and development of an interdisciplinary care plan.[2]
- In transitional care, **the interRAI Home Care (interRAI HC) is the comprehensive assessment most frequently used** to facilitate this process.
- Nurses and other care providers working in home-based care have expressed difficulty operationalizing the data generated from the interRAI HC.[3]
- **Practical nurses** often serve as primary nurses in these programs, therefore supporting their ability to operationalize standardized comprehensive assessment data to plan client care is critical.[4]

Objective

- The objective of this study is to co-design a point-of-care tool to support data-informed, person-centred care planning in community-based transitional care programs in Ontario.
- Our research question for this phase of the project was:

  What are Practical Nurses' perceptions of challenges and opportunities related to conducting the interRAI HC assessment and using assessment data at point-of-care?

Methodology

- Guided by the Participatory Research to Action (PR2A) framework[5] (Figure 1) we sought to authentically engage 'experts-by-experience' in all phases of the research.

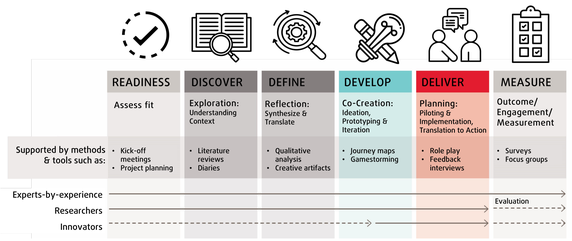


Figure 1: the Participatory Research to Action (PR2A) Framework

- This research used a multi-method participatory research approach with three phases: **1) interviews with Practical Nurses to discover the context**, 2) a co-design workshop to define the content of a point of care tool, and 3) a co-design workshop to develop the tool prototype. This poster presents on phase 1 of the research.

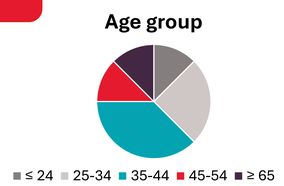
Phase 1 Methods

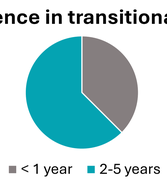
- Practical Nurses were recruited from SE Health's 20 transitional care programs across Ontario
- Data collection included:
  - Virtual interviews were 30-47 minutes in length.
  - A semi-structured interview guide was used to discover perceptions of interRAI HC, a) training, b) conducting assessments, c) using data for care planning, and d) using data for team collaboration.
- Interview transcripts were coded independently by two researchers who grouped data together based on challenges and opportunities. The research team then had consensus building conversations to generate themes related to challenges and opportunities in assessing and using interRAI HC data.[6]

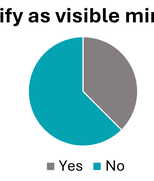
Results

Participant Characteristics

Eight Practical Nurses representing six @Home Programs were interviewed. All identified as heterosexual women.



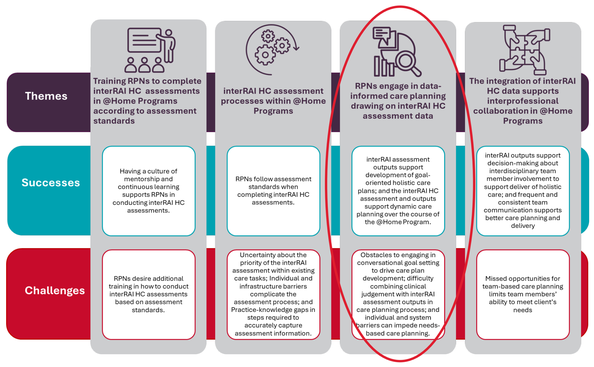




Overview of Findings

Based on interview data, we identified success and challenges related to interRAI training, assessments, care planning, and collaboration.

To support Phase 2 of this research, our findings today focus on the successes and challenges related to **engaging in data-informed care planning drawing on interRAI HC assessment data**.



Successes

interRAI assessment outputs support development of goal-oriented holistic care plans

- Holistic interRAI HC output reports help providers avoid tunnel vision on care needs based on clinical expertise

> it sometimes give you a broader picture than what you might be focusing on, because I know that we are doing holistic care and we are supposed to take the entire person into context, body, mind, soul … but sometimes we can get a little tunnel vision, I think, as a care provider only looking at one area because we, it's the one area that we want to focus on to manage the best

- Linking client goals to interRAI HC outputs facilitates development of personalized care plans

> in care planning, when we bring up the RAI, we look at the triggers and everything, we have to make sure that we deal with things in the way that the client would prefer … a big part of our program is going off of client goals … every client has a different goal, whether it's getting outside walking their dog or going for a shower

- Care planning for small measurable goals motivates clients to achieve their overall goal for the program

> They would say that, oh, after three days I want to be able to walk … we try to explain as well, okay, probably to get up, to stand up in the next few months, then probably start to walk, to exercise. … of course the long-term goal would always be there for them to see like, okay, this is really my goal, to encourage them more to do good every single day

- Risk levels in interRAI HC output reports support prioritization of care needs

> I like how it states what is high risk and what is low risk. We can really identify and maybe put more interventions or what if need be into the care plan based on the high need of that. Or if something's triggered in as [being] high need, then it maybe triggers me to think, oh, I need to send a referral for this, or this is an area that I really need to monitor more

The interRAI HC assessment and outputs support dynamic care planning over the course of the @Home Program

- The @Home program supports continuous assessments that are used to amend care plans

> We're constantly updating the care plans. The care plan is a work in progress, right? Once the RAI is completed. So, I think that the information that we're drawing from the RAI is already being used pretty effectively because it's not written in stone and you can constantly be amending it and using it

- Using client goals as an anchor for tracking progress and adjusting care plans

> Just focusing on basically their goals and making sure … that the goals are being looked at and that they are focusing on those goals and just kind of reminding them, 'oh, hey, you were mentioning that your goal was to do the stairs. How has that been going with physio? Or are you still finding that pretty hard to do'? So, we're pretty good at making sure that our clients try to reach their goals and if it is a goal that could be met

Challenges

Obstacles to engaging in conversational goal setting to drive care plan development

- Perception of goal-setting as a single question to complete required documentation

> "I just say, 'okay, what do you want to get back to doing that you were doing before?' And they usually have an answer for me. They're usually driving, working, maybe going back to my social activities … Sometimes they're like, 'oh, nothing.' Then I say, we have some clients that they have no rehab goals … We can't [make them] for them.

- Difficulties negotiating realistic expectations with clients and families about interventions and timelines for goal achievement

> Sometimes when there is family member in the home, sometimes it varies to what the patient['s] goal is versus to what the family wants the patient to achieve. … sometimes the family can be really demanding on. 'Oh, no, I don't want my dad to do that'. I want them to walk even though they haven't been walking for like how many years already and they're wheelchair bound

Difficulty combining clinical judgement with interRAI assessment outputs in care planning process

- Doubt in accuracy of interRAI assessment outputs instead of recognizing the need for further clinical investigation

> I think some of them [outputs] aren't necessarily always accurate. … say the abuse section, the client's perspective of being abused may be different from the actual definition… Like say they have memory problems and their significant other is shutting them down, but they're being polite about it. … the physical abuse trigger may come up, but if you actually look at the situation at hand and investigate what's going on, it's the client's anxiety

- Perception that care plan development should be automated based on interRAI HC assessment outputs

> …it matches 95% of the time your care planning for all of the things. I do sometimes, … if it will ask you, do they take medication by injection? Like daily medication by injection, you write, Yes. [But] For some reason that doesn't come up as a CAP. So then I know I'm always going back to the initial RAI and putting include a care aid.

- Misunderstanding how to prioritize care needs in the care planning process

> I did have some issues with other staff previously, when I double check their RAIs, how come they did not include in the care plan the other things that were triggered. So, they would just probably do shortcuts that, okay, I'll just do these two or three, so of course, how are we going to help that client?

Individual and system barriers can impede needs-based care planning

- Struggles with encouraging client engagement in care

> So sometimes, it would be difficult … if the patient is resistant to care. It's difficult to ask our team to go there and provide care because … you send somebody there, but he is refusing. … So sometimes that can be frustrating for our part that you try to help them, but you really can't help them because the patient would be actually refusing it.

- Care needs exceed what services and supports are available

> Sometimes they [clients] feel like we get the information from them and then there's not a whole lot that we can do … Our programs don't support stuff like housekeeping, and we don't drive people places. Yes, we can give them transportation options, but if there's a cognitive issue, transport services won't help them. … I feel like it's more frustrating for them like, well, why are you asking me all of this if you can't help with it."

Conclusions

- Participants highlighted Important competencies necessary for practical nurses to deliver data-informed, person-centered transitional care focused on what is most meaningful for older adults.
- By meaningfully engaging with practical nurses who are experts by experience, we identified challenges that reveal opportunities to better support nurses in their roles as primary clinicians.
- These findings have informed the next phase of our research, where we collaborated with transitional care providers to co-design point-of-care tools that address challenges in client engagement and conversation-based goal setting.

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6. ANALYSIS

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